from the office of

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REMARKS OF SENATOR EDWARD M. KENNEDY ON THE FIRST ANNIVERSARY OF THE COLUMBIA POINT NEIGHBORHOOD HEALTH CENTER, BOSTON, MASSACHUSETTS, DECEMBER 11, 1966

FOR IMMEDIATE RELEASE
Sunday, December 11, 1966

I am happy to be with you today to participate in this first anniversary of the Columbia Point Neighborhood Health Center. I have followed your efforts closely over the past year, for I am convinced that what you have begun here in the first neighborhood health center will quickly spread throughout the nation. By your efforts, and those of Tufts Medical School, and all others who have assisted in this project, you have not only assured the best in health care for your families and neighbors, but you have also begun a minor revolution in American medicine. Because of Columbia Point we are now thinking in new terms about the problem of bringing health care to the American people. The old myth that those of lower incomes are not concerned with adequate health care has been destroyed. You are concerned, you have displayed your concern in action, and by doing so you have presented a challenge to your government and to the medical profession. Columbia Point has closed the gap between the availability of professional health services and the desire and need for good health care by the people. And so the challenge is clear -- there are millions of people in this country who want and desperately need good health care, and they are not getting that care under current Federal, State, Local and private programs.

A year ago today this first neighborhood health center began the new approach to the delivery of health care. Before the Center began its operations only 28% of the 6,000 people living here had ever had a general medical check-up. Less than half of the mothers in Columbia Point saw a doctor during the most important first three months of their last pregnancy. Only 35% of the men had received an innoculation against infantile paralysis, and only 8% of the entire community had seen a dentist in the previous year.

Columbia Point, with a high proportion of children, women of child bearing age, and elderly was a virtual stranger to the medical profession -- in a city that is the nation's center of medical progress. 25% of the residents on the Point had serious medical conditions, but only one-third of these had consulted a doctor. The residents of this area saw a doctor on the average of only twice a year -- while the average citizen in our country has medical visits at least five times a year.

The advances in just one year, as a result of your effort, have been enormous. Of the 6,000 people who live here, the health center has now seen 5,400 on at least one occasion. That means that about one person from 96% of all families has used the services of the center. On twenty-eight thousand separate occasions people have visited the center's physicians, or the doctors have gone to them. So today, the average resident of Columbia Point is seeing a doctor over four times a year, -- that is, the national average of doctor visits has been reached in only 12 months.

So you have reason to be proud, and I am proud to be with you to share in your success. It was because of this community's work and the fact of this center that I took the opportunity in the United States Senate to introduce the concept of the neighborhood health center into the poverty program and make it a permanent part of that legislation. As a result, we now have some $60 million

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to create 20-30 new health centers across the nation in the next six months. It is my hope that every major city in this country will soon realize this new idea begun at Columbia Point. I shall press again in the coming year for more centers, more planning of centers, and more funds to do the job. I also plan to go beyond the question of health centers themselves to the larger problem of why they were needed, why we found that millions of Americans have been deprived of good health in this modern day.

In this nation considered rich with medical resources and care, it is a fact that unattended illness of the body and mind is a way of life to the millions who are poor. Men and women with incomes of $2,000 a year or less suffer heart diseases at a rate four times greater than the rest of the population, mental and nervous disorders are at a rate six times greater, and serious visual impairments are present ten times more often among the poor than the non-poor.

This prevalance of unattended disease and illness directly affects the economic status of these people, and by so doing perpetuates the presence of poverty in their life. For the poor who are fortunate enough to be employed, almost one-third of them carry such chronic conditions of various illnesses that severe limitations are placed upon their ability to work. Among the more privileged population, this is true of only 8%. To whatever extent health deficiencies cause the average worker to incur days lost at the job, that figure can be doubled for the poor -- those who do not have the benefit of salaries, sick time, or a working environment that easily tolerates their absence.

And so it is that poor health keep people poor, and this condition is passed on to their children - at least to those who survive. We know that there are ten countries that have lower rates of infant mortality and longer life expectacies than do we in the United States. This does not mean that we are without fine hospitals, it simply means that many of the poor rarely see the inside of these institutions.

Why is it that we have this environment of illness and suffering that the average American cannot begin to comprehend? Why is it that sheer poverty is the third leading cause of death in the city of New York? Why are the killer diseases of the poor still tuberculosis, influenza and pneumonia; diseases that the more fortunate have not suffered for a generation?

The answer lies only partially with the costs associated with medical care. The major cause of ill health among the poverty stricken is that medical care is not available to them in the same way that it is available to others. They have no personal relationship with a doctor, there is no office to to go, their neighborhoods have long ago lost many of the good physicians. What they do have is a confusing web of clinics, outpatient rooms, and emergency room corridors filled with impersonal staffs and their own neighbors waiting hours for attention -- usually to be told that they filled out the wrong form, are in the wrong lines, or suffer from symptoms that are only treated six or seven miles across the city. To the poor then, health care is emergency care, for the desire to be well is smothered by confusion, endless waiting and worst of all, personal indignity.

The immediate purpose of the health center is to change this situation. Health care must become an integral part of the lives of the poor with the quality of the care improved. And the key to this attempt lies in the coordination of all the medical services available in the community and the delivery of these services to those who are in need.

We are an advanced nation and we lead the world in medical progress. Yet the statistics of illness among the poor clearly show that we have failed to find a way to bring our medical progress to all. Over the years we have constructed a mass of legislation, agencies, and outlets of medical services that would confuse, if not discourage, the most determined seeking medical attention. The system we rely upon to deliver medical services to the poor is so fragmented that it is actually costing us lives.

There is no one cause for this situation. Legislation was passed at different times to meet different needs. The job of implementing legislation at the Federal level was placed in the various agencies and bureaus throughout the Government. The states and local governments each formed their own methods, at different times, to bring state and federal programs to the people. The net effect is that agencies

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on the Federal level stretching from the Department of Defense or the Office of Education to the Appalachian Regional Development Commission have responsibilities for various health programs. At the local level there are state, city and county health departments, private health agencies, welfare departments, and numerous types of hospitals attempting to provide medical service, under a confusing array of financial arrangements. It is left to the family that is poor to walk this maze, find the program, locate the agency, and seek out the service that so many are straining to give. And because the family must approach their health needs in this way, it follows that in this basic area of need, the family is fragmented itself. To the extent that there is a relationship between the illness of a mother, the health problems of a father, and the well-being of the children, the care received is bound to be less than what is needed.

Some small steps have been taken to meet this problem of coordination. Legislation was passed this year to encourage states to begin to plan ways to provide the kind of comprehensive health care proven so successful here at Columbia Point, although no money has been appropriated as yet. And medical and government experts are working in Washington to coordinate the efforts of the Federal government in all health matters. The success of this effort will depend upon the desire among the medical professions, governmental agencies and proponents of specific medical programs to put aside their rivalries and look beyond their own areas of interest to the overriding interest of those who are in need of full health care.

It seems to me, however, that another step must be taken while we debate the ways in which to coordinate our medical programs. We should have a national health policy -- a firm idea of the goals we are trying to reach, a set of priorities by which we can measure where we are, where we have failed, and how best to allocate our tax dollars.

In 1965, the entire nation spent over $40 billion for health services, supplies, research and construction. This is nearly 6% of our gross national product. One-fourt of these expenditures, or almost a billion dollars a month were from all levels of government, with $5.3 billion originating from the Federal government. These are staggering sums. I know that they all can be accounted for in terms of the many fine medical programs financed. But I am not sure that they can be accounted for in terms of measuring the worth of one program against another, one research effort against another, one building against another, because we have not framed our needs. We have not decided, for example, that is is important to end the alarming difference between white and non-white natal death rates; that we must eliminate the high death rate from communicable diseases among certain parts of our population, that the attack on air pollution as a serious health problem in our cities should have more or less priority than some other environmental health problem. I am sure that the creation of a national health policy will be difficult and require the assistance of many in our society. But until we make the effort we will continue to expend Federal funds for thousands of separate activities without any guarantee that these funds are accomplishing the greatest good for the greatest number.

By saying this I am not critical of any one medical program now in existence. We cannot be critical if we have no way of judging the worth of a program in an overall context -- but we can be critical of the fact that such judgments cannot be made.

I plan to reintroduce a bill calling for the development of an overall national health policy in the next Session of Congress. This bill will be similar to the amendment that I was fortunate enough to see through the Senate in the last Session. I feel, however, that while legislation may be desirable in this area it is not altogether necessary. Work could begin immediately within the Executive Branch, at the directive of the President, as part of an overall attempt to coordinate our Federal efforts in this field.

A national health policy appears to be far removed from a neighborhood health center. But I believe it is because we have failed to order our national health objectives that we have produced a fragmented structure of medical care delivery. And there is no doubt that it was this fragmentation that demanded the creation of health centers, in an attempt, no matter how limited at the present, to introduce a rational health program at the community level.

It is quite possible, then, that your undertaking here at Columbia Point will lead to many new and exciting developments in meeting the health cares of our nation. You have every reason to be proud of your efforts, and I look forward to joining with you again to celebrate even larger successes.

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